ATTACHMENT 7

Sample CMS 1500 claim form: one trip originating in a rural county with hospital discharge

HEALTH INCLIDANCE OF AIM FORM																	
1. MEDICARE MEDICAID		TIOX TIOX															
(Medicare #) (Medicaid	HEA	LTH PLAN	(= · · · · · · · · · · · · · · · · · ·														
2. PATIENT'S NAME (Last Name,	First Name, Middle	Initial)	3. F	ATIENT	'S BIRTH DATE							st Name	. Middle	Initial)			
Recipient, Im A.																	
5. PATIENT'S ADDRESS (No., Street)						7. INSURED'S ADDRESS (No., Street)											
609 Willow St			s	Self	Spouse												
6. PATIENT'S ADDRESS (No., Street) 6. O9 Willow St CITY Anytown ZIP CODE TELEPHONE (Include Area Code) (XXX) XXX-XXXX 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME 10. OTH READ BACK OF FORM BEFORE COMPLETING & SIGN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release or to process this claim. I also request payment of government benefits either to mysel below. SIGNED 14. DATE OF CURRENT: MM DD YY MI STATE BEAD BACK OF FORM BEFORE COMPLETING & SIGN READ BACK OF FORM BEFORE COMPLETING & SIGN READ BACK OF FORM BEFORE COMPLETING & SIGN READ BACK OF FORM BEFORE COMPLETING & SIGN C. OTH C. OTH 15. IF PATIE GIVE FIR 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NU 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 1, LV63.0) 3. L 1. LV63.0 3. L 1. LV63.0 3. L 1. LV63.0			ATIENT	STATUS			CITY						18	TATE			
			WI	Single Married Other													
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					Student	()											
9. OTHER INSURED'S NAME (La	st Name, First Name	e, Middle Initi	ial) 10.	. IS PATI	ENT'S CONDIT	ION RE	LATED TO:	11. INSURED	S POLIC	Y GRO	UP OR	FECA N	IUMBER				
A OTHER INCHIRED'S BOLICY O	D CDOLID NUMBER		——————————————————————————————————————	-1401 014	MENTO (OURDE		5 5 5 5 1 1 0 1 0 V										
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. INSURED'S DATE OF BIRTH MM DD YY									
h OTHER INSURED'S DATE OF BIPTY				NITO AC		h EMBLOVE	PO BIAT	E 00 6	CHCO.		<u>" 📙 </u>	F					
MM DD YY				CHAMPA GROUP FECA CHEER 18. INSURED'S IO. NUMBER (FOR PROGRAM IN ITEM 1) 12.34567890 12.3456780													
c. EMPLOYER'S NAME OR SCHOOL NAME						C. INSURANC	E PLAN	NAME (OR PRO	GRAM	NAME						
										AII IVINI	. 4F-041L						
						<u> </u>		d. IS THERE A	NOTHE	R HEAL	TH BE	NEFIT P	LAN?				
						n in f-	etion	13. INSURED	S OR AL	JTHORI	ZED PE	RSON'S	SSIGNA	TURE I au	thorize		
to process this claim. I also requ	est payment of gove	ernment bene	ofits either to my	yself or to	the party who a	ccepts	assignment	payment o services de	f medica escribed	l benefit below.	s to the	undersi	gned phy	sician or s	upplier for		
below.																	
SIGNEDDATE							SIGNED										
MM □ DD □ YY ■ INJURY (Accident) OR □ GIVE FIRST DATE MM □ DD □ YY							MM DD YY MM DD YY										
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172.10. NOMBER OF REFERRING PRISIDIAN								MM DD YY MM DD YY									
19. RESERVED FOR LOCAL USE																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)							22. MEDICAID RESUBMISSION										
_{1.1} V63.0			3				*	CODE		- 1	Onli	SINAL F	TEF. NO	•			
3								23. PRIOR AUTHORIZATION NUMBER									
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24. A DATE(S) OF SERVICE From	B Place	Type PR	OCEDURES.	D SERVICE	ES. OR SUPPLII	ES		F				1	J				
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PAT	IENT'S ACCO	UNT NO	27 ACC	EPT A	SSIGNMENT?	29 TOTAL CL	ABGE	L	N 4140	LINIT		00 541	NOE DO		
		-5			(For							ONI PA	"				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A					FACILITY WHE												
								& PHONE #									
apply to this bill and are made a part thereof.)								_	,								
J.M. authorized MM/DD/YY																	
J								Anytown, WI 55555 87654321 PIN# GRP#									
	CIL ON MEDICAL S		54.6	-405	PRINT OR T			D OMB-0938-00	00 500								